Complete Summary

GUIDELINE TITLE

2002 national guideline on the management of sexually acquired reactive arthritis.

BIBLIOGRAPHIC SOURCE(S)

Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD). 2002 national guideline on the management of sexually acquired reactive arthritis. London: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD); 2002. Various p. [68 references]

GUIDELINE STATUS

This is the current release of the guideline. This guideline updates a previously released version.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory information has been released.

On April 7, 2005, after concluding that the overall risk versus benefit profile is unfavorable, the FDA requested that Pfizer, Inc voluntarily withdraw Bextra (valdecoxib) from the market. The FDA also asked manufacturers of all marketed prescription nonsteroidal anti-inflammatory drugs (NSAIDs), including Celebrex (celecoxib), a COX-2 selective NSAID, to revise the labeling (package insert) for their products to include a boxed warning and a Medication Guide. Finally, FDA asked manufacturers of non-prescription (over the counter [OTC]) NSAIDs to revise their labeling to include more specific information about the potential gastrointestinal (GI) and cardiovascular (CV) risks, and information to assist consumers in the safe use of the drug. See the FDA Web site for more information.

Subsequently, on June 15, 2005, the FDA requested that sponsors of all non-steroidal anti-inflammatory drugs (NSAID) make labeling changes to their products. FDA recommended proposed labeling for both the prescription and over-the-counter (OTC) NSAIDs and a medication guide for the entire class of prescription products. All sponsors of marketed prescription NSAIDs, including Celebrex (celecoxib), a COX-2 selective NSAID, have been asked to revise the labeling (package insert) for their products to include a boxed warning, highlighting the potential for increased risk of cardiovascular (CV) events and the well described, serious, potential life-threatening gastrointestinal (GI) bleeding

associated with their use. FDA regulation 21CFR 208 requires a Medication Guide to be provided with each prescription that is dispensed for products that FDA determines pose a serious and significant public health concern. See the FDA Web site for more information.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Sexually acquired reactive arthritis including sexually acquired Reiter's syndrome

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Infectious Diseases
Obstetrics and Gynecology
Urology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To present a national guideline on the management of sexually acquired reactive arthritis

TARGET POPULATION

Patients in the United Kingdom with sexually acquired reactive arthritis including sexually acquired Reiter's syndrome

INTERVENTIONS AND PRACTICES CONSIDERED

Assessment/Diagnosis

1. Assessment of clinical features
2. In men, a Gram stained urethral smear
3. Identification of genital pathogens, particularly Chlamydia trachomatis or Neisseria gonorrhoeae.
4. Investigation of specificity and activity of arthritis

Management/Treatment

1. General advice and patient education
2. Further investigation by specialists
    - Full screening for sexually transmitted infections
    - Acute phase response: erythrocyte sedimentation rate (ESR) or C-reactive protein or plasma viscosity
    - Full blood count
    - Urinalysis
    - Liver and kidney function tests
    - Human leukocyte antigen-B27
    - X-rays of affected joints and sacro-iliac joints
    - Electrocardiogram
    - Echocardiogram
    - Ophthalmic evaluation including slit lamp assessment
    - HIV antibody test
    - Blood cultures
    - Stool culture (if enteritic reactive arthritis is suspected)
    - Serology specific for C trachomatis
    - Synovial fluid analysis for cell count, Gram stain, crystals, and culture
    - Synovial biopsy
    - Exclusion tests for other diseases with rheumatological features, for example, rheumatoid factor (rheumatoid arthritis), plasma urate (gout), chest X-ray, and serum angiotensin-converting enzyme level (ACE) (sarcoidosis).
3. Liaison with and/or referral by genitourinary medicine specialists to other specialists for all patients with significant involvement of extra-genital systems
4. Further diagnostic testing listed above in the section "assessment/diagnosis"
5. Treatment of constitutional symptoms: rest, non-steroidal anti-inflammatory drugs
6. Antimicrobial therapy for any genital infection identified
7. First line arthritis therapy
    - Rest with the restriction of physical activity
    - Physiotherapy
    - Physical therapy
    - Non-steroidal anti-inflammatory drugs
    - Intra-articular corticosteroid injections
8. Second line arthritis therapy

As above plus:

- Systemic corticosteroids and anti-osteoporosis prophylaxis
- Sulphasalazine
- Methotrexate
- Azathioprine
- Gold salts and D-penicillamine
- Short course antibiotic therapy for the treatment of concomitant urogenital infection
- Medical synovectomy using Yttrium-90, osmic acid, or Samarium-153.
- Surgery: synovectomy and arthroplasty

9. Enthesitis therapy
    - Rest
    - Physiotherapy and ultrasound
    - Non-steroidal anti-inflammatory drugs
    - Local corticosteroid injection
    - Radiotherapy
    - Surgery
10. Treatment of mucous membrane and skin lesions related to arthritis
    - No treatment for mild lesions
    - Keratinolytic agents, such as topical salicylate or corticosteroid preparations
    - Calcipotriol cream/ointment
    - Methotrexate
    - Retinoids
11. Management of eye lesions related to arthritis
    - Manage with ophthalmological advice
    - Slit lamp assessment to diagnose uveitis
    - Therapy for uveitis: corticosteroid eye drops or oral corticosteroids and mydriatics
12. Management of post-inflammatory pain and fatigue
    - Explanation and patience
    - Low dose tricyclic drugs, such as amitriptyline
13. Prophylaxis considerations
14. Considerations for pregnant and breastfeeding women
15. Sexual partner notification, treatment, and contact tracing, as appropriate
16. Follow-up

MAJOR OUTCOMES CONSIDERED

- Signs and symptoms of sexually acquired reactive arthritis
- Rates of short term and long term disability
- Rates of joint and/or extra-articular recurrences
- Adverse effects of treatment

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

In compiling these guidelines, evidence was sought from Medline (U.S. National Library of Medicine), Biomed, the Cochrane Library and authoritative reviews. Additional papers referenced by articles identified by the search strategy were also reviewed. Searches were made from 1966 to November 2000 using the headings "reactive arthritis", "Reiter's syndrome", "infectious arthritis", and "spondyloarthropathy".

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence:

Ia

- Evidence obtained from meta-analysis of randomised controlled trials

Ib

- Evidence obtained from at least one randomised controlled trial

IIa

- Evidence obtained from at least one well designed controlled study without randomisation

IIb

- Evidence obtained from at least one other type of well designed quasi-experimental study

III

- Evidence obtained from well designed non-experimental descriptive studies such as comparative studies, correlation studies, and case control studies

IV

- Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The revision process commenced with authors being invited to modify and update their 1999 guidelines. These revised versions were posted on the website for a 3 month period and comments invited. The Clinical Effectiveness Group and the authors concerned considered all suggestions and agreed on any modifications to be made.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grading of Recommendations:

A (Evidence Levels Ia, Ib)

- Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation.

B (Evidence Levels IIa, IIb, III)

- Requires availability of well conducted clinical studies but no randomised clinical trials on the topic of recommendation.

C (Evidence Level IV)

- Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities.
- Indicates absence of directly applicable studies of good quality.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The initial versions of the guidelines were sent for review to the following:

- Clinical Effectiveness Group (CEG) members
- Chairs of UK Regional GU Medicine Audit Committees who had responded to an invitation to comment on them
- Chair of the Genitourinary Nurses Association (GUNA)
- President of the Society of Health Advisers in Sexually Transmitted Diseases (SHASTD)
- Clinical Effectiveness Committee of the Faculty of Family Planning and Reproductive Health Care (FFP).

Comments were relayed to the authors and attempts made to reach a consensus on points of contention with ultimate editorial control resting with the Clinical Effectiveness Group. Finally, all the guidelines were ratified by the councils of the two parent societies.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions of the levels of evidence (I-IV) and grades of recommendation (A-C) are repeated at the end of the "Major Recommendations" field.

Diagnosis

The diagnosis of sexually acquired reactive arthritis involves three components.

- Recognition of the typical clinical features of spondyloarthropathy.
- Demonstration of evidence of genitourinary infection by the identification of:
    - Urethritis in men. Urethral discharge, dysuria, and/or epididymo-orchitis may be present. Asymptomatic cases are not infrequent. Microscopic confirmation is by a Gram stained urethral smear demonstrating greater than or equal to 5 polymorphonuclear leucocytes per high power (x 1000) microscopic field, or greater than or equal to 10 polymorphonuclear leucocytes per high power (x 1000) microscopic field on a first void urine sample.
    - Muco-purulent cervicitis in women. A purulent or muco-purulent endocervical exudate, with or without easily induced cervical bleeding, and/or lower abdominal pain may be present. However, cervical infection is frequently asymptomatic.
    - The identification of genital pathogens, particularly Chlamydia trachomatis or Neisseria gonorrhoeae. Full screening for sexually transmitted infections (STIs) is essential.

    - Please refer to the related UK national guidelines (see the National Guideline Clearinghouse [NGC] summaries) Non-gonococcal Urethritis, Chlamydia trachomatis Infection, and Gonorrhoea.
- Investigation of specificity and activity of arthritis.

Management

General advice

The principles of management are governed by the expectation that sexually acquired reactive arthritis is a self-limiting disease in the majority of patients.

Patients should be advised to avoid unprotected sexual intercourse until they and their partner(s) have completed treatment and follow-up for any genital infection identified.

Patients should be given a detailed explanation of their condition with particular emphasis on the long-term implications for the health of themselves and their partner(s). This should be reinforced by giving them clear and accurate written information.

Further investigation

The following investigations are essential, often useful or sometimes useful. (Keat et al., 1980; Leirisalo et al., 1982; Kousa, 1978; Csonka, 1979a; Keat et al., 1979; Keat, 1983; Toivanen, 1998; Csonka, 1979b; Good, 1979; Popert, Gill, & Laird, 1964; Bas et al., 1996) Genitourinary medicine specialists are advised to liaise with and/or refer to other specialists including rheumatologists, ophthalmologists, and dermatologists for all patients with significant involvement of extra-genital systems. It is advised that all patients with sexually acquired reactive arthritis be referred to an ophthalmologist, if possible, for slit lamp assessment. Essential investigations should be performed by genitourinary medicine specialists while other investigations are suggested following appropriate referral.

Essential

- Full screening for sexually transmitted infections
- Acute phase response
    - Erythrocyte sedimentation rate (ESR)

      or

    - C-reactive protein

      or

    - Plasma viscosity
- Full blood count
- Urinalysis

Investigations which are often useful

- Liver and kidney function tests
- Human leukocyte antigen B27 (HLA-B27)
- X-rays of affected joints and sacro-iliac joints
- Electrocardiogram
- Echocardiogram
- Ophthalmic evaluation including slit lamp assessment

Investigations which are sometimes useful

- HIV antibody test
- Blood cultures
- Stool culture (if enteritic reactive arthritis is suspected)
- Serology specific for C trachomatis
- Synovial fluid analysis for cell count, Gram stain, crystals, and culture
- Synovial biopsy
- Exclusion tests for other diseases with rheumatological features, for example, rheumatoid factor (rheumatoid arthritis), plasma urate (gout), chest X-ray, and serum angiotensin-converting enzyme (ACE) level (sarcoidosis).

Treatment

Treatment is directed at several distinct elements of the condition. It is advisable that advice/assessment is obtained from relevant specialists as indicated above.

Constitutional symptoms

- Rest
- Non-steroidal anti-inflammatory drugs (NSAIDs)

Genital infection

Antimicrobial therapy for any genital infection identified should be as in uncomplicated infection. Please refer to the relevant UK national infection guidelines (see "Companion Documents"). Whether short course antibiotic treatment of the acute genital infection influences the non-genital aspects of sexually acquired reactive arthritis is controversial, with the probability being that it does not once the arthritis is manifest (level of evidence Ib, grade of recommendation A) (Keat et al., 1979; Popert, Gill, & Laird, 1964; Fryden et al., 1990; Leirisalo-Repo, 1993; Bardin et al., 1992).

Arthritis

First line therapy

- Rest with the restriction of physical activity, especially weight bearing activity where leg joints are involved. Balance with the use of physiotherapy to prevent muscle wasting (IV, C) (Toivanen, 1998; Toivanen & Toivanen, 1995; Cuellar & Espinoza, 1996; Leirisalo-Repo, 1998).

- Physical therapy with the use of cold pads to alleviate joint pain and oedema (IV, C) (Toivanen, 1998; Toivanen & Toivanen, 1995; Cuellar & Espinoza, 1996; Leirisalo-Repo, 1998).
- Non-steroidal anti-inflammatory drugs are well established as efficacious agents in many inflammatory arthritides and form the mainstay of therapeutic management. It is important that they are used regularly to achieve the maximum anti-inflammatory effect. There is no definite drug of choice (IIb, B) (Toivanen, 1998; Toivanen & Toivanen, 1995; Cuellar & Espinoza, 1996; Leirisalo-Repo, 1998; Brooks, 1998; Juvakoski & Lassus, 1982; Dougados et al., 1994).
- Intra-articular corticosteroid injections, especially valuable for single troublesome joints. May also be used for inflamed sacro-iliac joints. Proven value in other inflammatory arthritides but there are no randomised placebo-controlled trials of its use in sexually acquired reactive arthritis (IV, C) (Toivanen, 1998; Toivanen & Toivanen, 1995; Leirisalo-Repo, 1998; Blyth, Hunter, & Stirling, 1994; Bird, 1998; Calin, 1979; Gunaydin et al., 2000).

Second line therapy (moderate/severe arthritis/failure of first line)

As above plus:

- Systemic corticosteroids. If used, consideration should be given to anti-osteoporosis prophylaxis. Corticosteroids are valuable as short courses usually beginning with oral doses of 10-25 mg daily where severe symptoms arise from several joints, often in the presence of constitutional illness. In rheumatoid arthritis it has been shown to suppress inflammation but there are no randomized placebo-controlled trials of its use in sexually acquired reactive arthritis (IV, C) (Toivanen, 1998; Toivanen & Toivanen, 1995; Kirwin, 1998; Homik et al., 2000; Cranney et al., 2000).
- Sulphasalazine. Indicated where disabling symptoms persist for 3 or more months, or evidence of erosive joint damage is present. Its effect is maximum on peripheral articular manifestations. Sulphasalazine reduces the duration of active synovitis but probably does not influence ultimate recovery. High doses, 3 g daily, are associated with significant toxicity, especially gastrointestinal, which may necessitate cessation of treatment, whereas 2 g daily appears equally effective and better tolerated (Ib, A) (Toivanen, 1998; Toivanen & Toivanen, 1995; Dougados et al., 1995; Clegg et al., 1996; Egsmose et al., 1997; Clegg, Reda, & Abdellatif, 1999).
- Methotrexate. Indicated where disabling symptoms persist for 3 or more months, or evidence of erosive joint damage is present. Doses range from 7.5-15 mg orally as a single weekly dose. Oral folic acid should be given, usually as a single 5 mg dose weekly, with or on the day after the methotrexate dose. Methotrexate is favoured by many physicians because of the ease of weekly oral administration and the favourable responses seen in rheumatoid disease and psoriatic arthritis. Only case reports of its use in sexually acquired reactive arthritis have been published (IV, C) (Toivanen, 1998; Toivanen & Toivanen, 1995; Cuellar & Espinoza, 1996; Owen & Cohen, 1979).
- Azathioprine. Indicated where disabling symptoms persist for 3 or more months, or evidence of erosive joint damage is present. Doses of 1-4 mg/kg/body weight per day may be used (III, B) (Toivanen, 1998; Toivanen & Toivanen, 1995; Calin, 1986).

- Gold salts and D-penicillamine. These drugs are occasionally used when persistent polyarthritis is present. No randomized placebo-controlled trials have been published concerning their use in sexually acquired reactive arthritis (IV, C) (Toivanen, 1998; Toivanen & Toivanen, 1995).
- Antibiotics. Short course antibiotic therapy used for the treatment of concomitant uro-genital infection may reduce the risk of recurrent arthritis developing in individuals with a history of reactive arthritis but otherwise there is little evidence of benefit in arthritis (Ib, A) (Keat et al., 1979; Popert, Gill, & Laird, 1964; Fryden et al., 1990; Leirisalo-Repo, 1993; Bardin et al., 1992). Longer course antibiotic therapy has been considered. However, many studies have had small numbers of individuals with sexually acquired reactive arthritis, often the trial antibiotic has been ciprofloxacin, a drug with low efficacy against C. trachomatis, and in the main antibiotic therapy has been commenced after the arthritis has established. Antibiotics may also have anticollagenolytic properties. (Nordstrom et al., 1998) Conflicting results have been obtained, with one study identifying a non-significant improvement in sexually acquired reactive arthritis with 3 months treatment with ciprofloxacin compared to placebo, albeit with a diminishing effect after 12 months, while others have identified no benefit (Sieper et al., 1999; Wakefield et al., 1999; Yli-Kerttula et al., 2000) Lymecycline administered for 3 months, in one study, has been shown to reduce the duration of arthritis in C trachomatis triggered sexually acquired reactive arthritis but no such effect was seen in a comparative study of 2 weeks versus 4 months of doxycycline therapy (Lauhio et al., 1991; Wollenhaupt et al., 1997). The role of long term antimicrobial therapy, particularly in non-chlamydial sexually acquired reactive arthritis, is not yet established (Ib, A) (Leirisalo-Repo, 1993; Sieper et al., 1999; Wakefield et al., 1999; Yli-Kerttula et al., 2000; Lauhio et al., 1991; Wollenhaupt et al., 1997; Pott, Wittenborg, & Junge-Hulsing, 1988; Williams et al., 1989).
- Medical synovectomy using Yttrium-90, osmic acid, or Samarium-153. All have been shown to have short term benefit in chronic mono-articular synovitis. Advantages over intra-articular corticosteroid injections have not been confirmed (Ib, A) (Bird, 1998; O'Duffy et al., 1999).
- Surgery. Exceptionally, surgical treatment including synovectomy and arthroplasty, is valuable (Toivanen & Toivanen, 1995).

Enthesitis

- Rest (IV, C) (Toivanen, 1998)
- Physiotherapy and ultrasound
- Non-steroidal anti-inflammatory drugs (IV, C) (Toivanen, 1998)
- Local corticosteroid injection (IV, C) (Leirisalo-Repo, 1998; Bird, 1998; Calin, 1979)
- Radiotherapy for persistent disabling heel pain, exceptionally
- Surgery, exceptionally

Mucous membrane and skin lesions

- No treatment for mild lesions
- Keratinolytic agents, such as topical salicylate or corticosteroid preparations, in mild to moderate cases (IV, C) (Toivanen, 1998; Owen & Cohen, 1979)
- Calcipotriol cream/ointment in mild to moderate cases (IV, C) (Thiers, 1997)

- Methotrexate, if severe lesions (IV, C) (Toivanen, 1998; Owen & Cohen, 1979)
- Retinoids, if severe lesions (IV, C) (Toivanen, 1998; Louthrenoo, 1993)

Eye lesions

- Should be managed with ophthalmological advice. Slit lamp assessment is essential to diagnose uveitis which if untreated may result in irreversible visual loss. Therapy for uveitis consists of corticosteroid eye drops or oral corticosteroids and mydriatics (IV, C) (Toivanen, 1998).

Post-inflammatory pain and fatigue

- Explanation and patience
- Low dose tricyclic drugs, such as amitriptyline 10-25 mg at night, if severe symptoms.

Prophylaxis

- In addition to the advice to avoid unprotected sexual intercourse until they and their partner(s) have completed treatment and follow-up for any genital infection identified, patients should be advised to avoid potentially "triggering infections" in the future, either urogenital or enteric. Hence, safer sexual practice should be discussed and the importance of food hygiene stressed.

Pregnancy and breast feeding

- All medications should be avoided during pregnancy and breast-feeding where possible.
- Antibiotics. Please refer to the relevant UK national infection guidelines (see "Companion Documents").
- Non-steroidal anti-inflammatory drugs may potentially produce sub-fertility as a result of the luteinised unruptured ovarian follicle syndrome. (Smith et al., 1996) Non-steroidal anti-inflammatory drugs, used regularly during pregnancy, may produce premature closure of the foetal ductus arteriosus, oligohydramnios, delayed onset, and increased duration of labour. (de Witt, van Mourik, & Wiesenhaan, 1988; British National Formulary, 2000a) Advice regarding breastfeeding depends on the specific non-steroidal anti-inflammatory drug being used. (British National Formulary, 2000a)
- Corticosteroids are low risk but if the daily use is 10 mg or more, foetal/infant adrenal suppression may occur (British National Formulary, 2000a).
- Sulphasalazine appears to have only small theoretical risks but should be used with caution in pregnancy and breastfeeding. It may induce oligospermia in men (British National Formulary, 2000a, 2000b).
- Azathioprine should not be initiated during pregnancy, if possible (British National Formulary, 2000a).
- Methotrexate and retinoids are teratogenic and contraindicated during pregnancy and breast-feeding. Both men and women using methotrexate should avoid conception during drug taking and for at least 6 months after. Women using retinoids should be advised to use adequate contraception for at least 1 month before treatment, during treatment, and for at least 2 years after stopping treatment (British National Formulary, 2000a).

- Gold salts should be avoided during pregnancy and breastfeeding. Women should avoid conception during and for at least 6 months after treatment (British National Formulary, 2000a).

Sexual partners

- Partner notification, treatment, and the contact tracing period is dependent on the genital infection identified. Please refer to the relevant UK national infection guidelines (see "Companion Documents").

Follow up

- Genitourinary medicine follow-up is dependent on the genital infection identified. Please refer to the relevant UK national infection guidelines (see "Companion Documents").
- Extra-genital manifestations should be followed up under the direction of the relevant specialist.

Definitions:

The following rating scheme was used for major management recommendations.

Levels of Evidence:

Ia

- Evidence obtained from meta-analysis of randomised controlled trials

Ib

- Evidence obtained from at least one randomised controlled trial

IIa

- Evidence obtained from at least one well designed controlled study without randomisation

IIb

- Evidence obtained from at least one other type of well designed quasi-experimental study

III

- Evidence obtained from well designed non-experimental descriptive studies such as comparative studies, correlation studies, and case control studies

IV

- Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Grading of recommendations:

A (Evidence levels Ia, Ib)

- Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation.

B (Evidence levels IIa, IIb, III)

- Requires availability of well conducted clinical studies but no randomised clinical trials on the topic of recommendation.

C (Evidence level IV)

- Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities.
- Indicates absence of directly applicable studies of good quality.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is graded and identified for select recommendations (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate diagnosis, management, and treatment of patients in the United Kingdom with sexually acquired reactive arthritis.

POTENTIAL HARMS

Medication Side Effects

- Systemic corticosteroids: If used, consideration should be given to anti-osteoporosis prophylaxis. During pregnancy or breastfeeding, corticosteroids are low risk, but if the daily use is 10 mg or more, foetal/infant adrenal suppression may occur.
- Sulphasalazine: High doses, 3 g daily, are associated with significant toxicity, especially gastrointestinal, which may necessitate cessation of treatment, whereas 2 g daily appears equally effective and better tolerated. Sulphasalazine may induce oligospermia in men.
- Non-steroidal anti-inflammatory drugs may potentially produce sub-fertility as a result of the luteinised unruptured ovarian follicle syndrome. Non-steroidal anti-inflammatory drugs, used regularly during pregnancy, may produce premature closure of the foetal ductus arteriosus, oligohydramnios, delayed onset, and increased duration of labour. Advice regarding breastfeeding depends on the specific non-steroidal anti-inflammatory drug being used.

Subgroups Most Likely to be Harmed:

- Women who are pregnant or breastfeeding should avoid all medications during pregnancy and breast-feeding, where possible.
- Sulphasalazine appears to have only small theoretical risks but should be used with caution in pregnancy and breastfeeding
- Azathioprine should not be initiated during pregnancy, if possible.
- Gold salts should be avoided during pregnancy and breastfeeding. Women should avoid conception during and for at least 6 months after treatment

CONTRAINDICATIONS

CONTRAINDICATIONS

Methotrexate and retinoids are teratogenic and contraindicated during pregnancy and breast-feeding. Both men and women using methotrexate should avoid conception during drug taking and for at least 6 months after. Women using retinoids should be advised to use adequate contraception for at least 1 month before treatment, during treatment, and for at least 2 years after stopping treatment.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The Clinical Effectiveness Group reminds the reader that guidelines in themselves are of no use unless they are implemented systematically. The following auditable outcome measures are provided:

- Duration of inability to work
- Need for admission to hospital
- Presence of erosive joint damage
- Duration to full recovery
- Number of joint and/or extra-articular recurrences over a 2 year period after the initial episode
- Presence of long term disability

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD). 2002 national guideline on the management of sexually acquired reactive arthritis. London: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD); 2002. Various p. [68 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1999 Aug (revised 2002)

GUIDELINE DEVELOPER(S)

British Association of Sexual Health and HIV - Medical Specialty Society

SOURCE(S) OF FUNDING

Not stated

GUIDELINE COMMITTEE

Clinical Effectiveness Group (CEG)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Authors: Andrew Keat; Elizabeth Carlin

Clinical Effectiveness Group (CEG) Members: Keith Radcliffe (Chairman); Imtyaz Ahmed-Jushuf; Jan Welch; Mark FitzGerald; Janet Wilson

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Conflict of Interest: None

GUIDELINE STATUS

This is the current release of the guideline. This guideline updates a previously released version.

GUIDELINE AVAILABILITY

Electronic copies: Available from the British Association for Sexual Health and HIV Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- UK national guidelines on sexually transmitted infections and closely related conditions. Introduction. Sex Transm Infect 1999 Aug;75(Suppl 1):S2-3.

The following is also available:

- Revised UK national guidelines on sexually transmitted infections and closely related conditions 2002. Sex Transm Infect 2002;78:81-2

The following related guidelines are available:

- 2002 national guideline on the management of non-gonococcal urethritis. London: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD); 2002. Various p. See the National Guideline Clearinghouse (NGC) summary.
- 2002 national guideline for the management of Chlamydia trachomatis genital tract infection. London: Association for Genitourinary Medicine (AGUM), Medical Society for the Study of Venereal Disease (MSSVD); 2002. Various p. See the NGC summary.
- National guideline on the diagnosis and treatment of gonorrhoea in adults 2005. London (England): British Association for Sexual Health and HIV (BASHH); 2005. 9 p. See the NGC summary.

Print copies: For further information, please contact the journal publisher, BMJ Publishing Group.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on December 8, 2000. The information was verified by the guideline developer on January 12, 2001. This summary was updated on August 5, 2002. This summary was updated on May 3, 2005 following

the withdrawal of Bextra (valdecoxib) from the market and the release of heightened warnings for Celebrex (celecoxib) and other nonselective nonsteroidal anti-inflammatory drugs (NSAIDs). This summary was updated by ECRI on June 16, 2005, following the U.S. Food and Drug Administration advisory on COX-2 selective and non-selective non-steroidal anti-inflammatory drugs (NSAIDs).

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DISCLAIMER

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Date Modified: 9/25/2006